

**GEORGIA STATE BOARD OF WORKERS' COMPENSATION****NOTICE OF INTENT TO BECOME A PARTY OF INTEREST**

Instructions: Any group insurance company or other disability benefits provider who has made payments in the employee's behalf for disability benefits pursuant to an employer paid plan, and who wishes to be named a party of interest to obtain reimbursement for those expenses which have been paid, shall file this form with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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**A. IDENTIFYING INFORMATION**

<b>EMPLOYEE</b>	County of Injury	Address			
Employee E-mail		City	State	Zip Code	
<b>EMPLOYER</b>	Name	<b>INSURER/ SELF INSURER</b>	Name		
Address		<b>CLAIMS OFFICE</b>	Name		
		Address			
City	State	Zip Code	City	State	Zip Code
Employer E-mail		Claims E-mail		SBWC ID# (five digit no)	

**B. NOTICE**

Notice is hereby given that: _____ (Print Name of provider)			
Address			Phone
City	State	Zip Code	E-mail
has made payments in the amount of \$ _____ on the employee's behalf for disability benefits and desires to be made a party at interest in this claim for reimbursement for funds so expended, should liability be established under Title 34-9.			

**C. CERTIFICATION**

<input type="checkbox"/> I hereby certify that I have sent a copy of this form to all parties and counsel in this claim, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.		
Print Name Here	Signature	Date
Phone	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).